ARUP LABORATORIES

A nonprofit enterprise of the University of Utah and its Department of Pathology

500 Chipeta Way
Salt Lake City, UT 84108-1221
phone: 801-583-2787 | toll free: 800-242-2787
fax: 801-584-5249 | aruplab.com

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

PEDIATRIC/ADULT CYTOGENETIC TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Sex Assigned at Birth: ☐ Female ☐ Male ☐ Intersex **Gender Identity (optional):** ☐ Female ☐ Male ☐ _____

Ordering Provider: _____ **Provider's Phone:** _____

Practice Specialty: _____ **Provider's Fax:** _____

Genetic Counselor: _____ **Counselor's Phone:** _____

Sample Type: ☐ Peripheral blood ☐ Cord blood ☐ Buccal ☐ Skin Biopsy

Desired Testing

☐ **2002289** Chromosome analysis, peripheral blood

☐ **2002287** Chromosome analysis, rule out mosaicism

☐ **2003414** Cytogenomic SNP microarray, blood

☐ **2006267** Cytogenomic SNP microarray, buccal swab

☐ **2005763** Chromosomes with reflex to microarray

☐ **2002286** Chromosome analysis, skin biopsy

☐ **0040208** Newborn FISH panel (13, 18, 21, X, Y)

☐ **2002299** FISH for specific condition (specify probe or condition): _____

_____

Indication for Testing (check all that apply—*required*)

☐ Suspected diagnosis of: ☐ Down syndrome ☐ Trisomy 18 ☐ Trisomy 13 ☐ Turner syndrome ☐ Other: _____

_____

☐ High risk cfDNA screen (NIPT): ☐ T21 ☐ T18 ☐ T13 ☐ 45,X ☐ XXX ☐ XXY ☐ XYY ☐ Other: _____

☐ Atypical cfDNA screen (NIPT) for chromosome: ☐ 13 ☐ 18 ☐ 21 ☐ X ☐ Y ☐ Other: _____ ☐ CNV ☐ Mosaicism

☐ **Maternal** finding by cfDNA for chromosome: ☐ 13 ☐ 18 ☐ 21 ☐ X ☐ Y ☐ Other: _____ ☐ CNV ☐ Mosaicism

☐ Congenital anomalies (specify): _____

_____

☐ Dysmorphic features (specify): _____

☐ Cardiac defect (specify): _____

_____

☐ Genital anomalies: _____

☐ Ambiguous genitalia

☐ Intellectual and/or developmental disability

☐ Autism/Autism spectrum disorder

☐ Learning disabilities

☐ Infertility

☐ Recurrent miscarriage

☐ Partner with recurrent miscarriage (partner's name):

_____

☐ Other (specify): _____

_____

☐ Family history (complete information in box below)

☐ There is a family history of a chromosome or microarray abnormality in patient's (relationship to patient): _____

☐ Confirm an abnormality *previously identified in this patient.*

IF EITHER OF THE ABOVE IS TRUE, to ensure correct testing, please provide:

1. The name/DOB of the previously tested family member (if not patient): _____
2. The abnormality found in the patient or family member: _____
3. **A copy of the family member's/patient's previous test results.**

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 5222.

Master Label